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ABSTRACT

Group therapy, in general, and positive peer culture (PPC) programs, in particular, are discussed in terms of treatment characteristics and effects on maladaptive adolescent behavior. Topics covered include the three phases (inclusion, power, and affection) of group treatment, difficulties (negative group experiences) produced by group therapy, PPC's emphasis on peer control, and problems in evaluating PPC programs. (SB)

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Positive Peer Culture:

An Evaluation

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Positive Peer Culture: An Evaluation

There are at least three inherent advantages of group treatment over individual treatment modalities in addition to the generally recognized potential economy of group intervention. Individuals are confronted with disparate group goals, interpersonal sharing is necessitated, and obvious social norms and immediate feedback are consistently available (Stieper & Wiener, 1965). These characteristics are believed to be found within almost all group methods for dealing with problem behavior, cutting across philosophical or theoretical boundaries. Positive Peer Culture (PPC) is a group treatment method which also functionally conforms to these characteristics. The first portion of this paper offers a generic summary of group intervention in order that a basis for differential evaluation of PPC may be developed.

General Characteristics of Group Treatment

Group dynamics have been found to include three regular phases of development which parallel stages of individual life development (Kaplan & Sadock, 1972). The three stages are: inclusion (primary question of whether a member is loved and accepted and belongs), power (primary question of whether a member can gain autonomy and challenge the power of the group leader), and affection (primary concern with equality and giving rather than with taking). The corresponding three stages of individual development are narcissism and symbiosis,

individuation, and object constancy and mutuality. Termination of a complete group or of the involvement of separate members can occur at any time, regardless of the developmental stage attained by the group system.

Successful psychotherapy frequently seems to involve replacement of chronic feelings of failure and helplessness with a move toward synthesizing growth and competency. Successful therapy can result in personal ability to view difficulties interpersonally, development of adaptive interpersonal behaviors, and achievement of a sense of mastery over unpleasant events (Strupp, Fox, & Lessler, 1969).

Psychological treatment always results in gains and losses in experienced power in relation to environmental interaction. The interactional dimensions of group therapy may have potential influence for particularly strong social tendencies; guided group interaction techniques (forerunner to PPC) are purportedly especially intended to teach conformity and are frequently applied in correctional institutions for that purpose (Halleck, 1971). Such an intent is, to a degree, contrary to other possible group objectives such as "growth" or "personal freedom."

Group treatment can produce difficulties, of course, and it has been suggested that conventional group therapy could potentially result in more negative experiences than traditional individual therapy (Hartley, et al, 1976). Premorbid personality characteristics seem to influence negative personal group experiences (Hartley, et al, 1976); group treatment does not seem to be appropriate for each potential consumer, just as no other form of treatment can be given blanket recommendation.

Hartley and associates (1976) have presented a summary of effective leader characteristics and have categorized two types which seem to correspond with higher group casualty rates: intense, emotionally stimulating and charismatic types, and laissez-faire personalities who delegate directive responsibilities to members. Not only can one make modest predictions about leader effectiveness, it is also possible to make some differentiation between characteristics of successful dispensers of individual treatment and successful group leaders (Geller & Bezrins, 1976). Prominent group leaders have been found to be detail-oriented, stimulus seeking, interpersonally ascendent, and relationship oriented. A general functional characteristic of experienced therapists might be that they do not vary greatly according to different "schools" of therapy. This may not be true of less experienced or relatively untrained therapists or group leaders.

Major Characteristics of PPC

Certain characteristics are typical of most PPC programs. For example, individuals frequently begin PPC involvement while aware of the probable amount of time to be spent in that milieu. Foreknowledge of time limits may facilitate positive (or apparently positive) results particularly if a participant is inclined to seek change.

PPC can incorporate rather comprehensive environmental control while encouraging symptom expression within the general context of daily behavior. PPC operates on the assumption that problem behaviors are more often attributable to a deviant subculture than to mental disorder. Thus, undesirable behaviors must be emitted in order to be dealt with. Delinquent youths are common recipients of PPC treatment, often within the confines of some correctional facility, and, for this

reason, may often be unwilling or disinterested participants.

While a personal relationship with the group leader is not necessary, it is important that the leader receive the respect of group members. Leaders do not receive extensive formal training, nor is such training considered necessary for successful PPC implementation. This attitude may be significant in light of the evidence that groups can foster negative experiences and are directly influenced by leader characteristics. PPC's emphasis on peer control has basis in the typical susceptibility of adolescents to the influence of their peers. It is certainly possible, of course, that youngsters with inadequate ego development could be easily victimized by aggressive delinquents unless a skillful leader exercised necessary controls.

PPC, like many other treatment methods, is difficult to properly evaluate because of the complex interaction of several variables which results in a lack of adequate procedural controls. What would appear to be successful amelioration of maladaptive behaviors might be a transient response to overt or covert pressure to conform to standards established by either group or institution. Another potential source of spurious success arises when a facility switches to a new treatment method, generating staff enthusiasm and a Hawthorne Effect for group members.

Group comparisons always tend to lose sight of significant individual effects. Important type-treatment interactions are rather easily masked as variance. In a similar sense, group leader variables are commonly given insufficient consideration. Leader characteristics may have greater potential for disparity and may be more significant than other variables included within any range of legitimate PPC characteristics.

While opinions are important, especially to those who hold them, "opinion questionnaires" are commonly of little value. The attitudes of judges or attorneys may be quite sensible but they do not necessarily have any correspondence with the actual interventive efforts provided for disruptive youths. Appraisal by persons not directly involved with treatment is especially undesirable because the method of treatment may resemble a model in name only. In other words, reports of PPC effectiveness do not guarantee that PPC was actually the method of treatment. In a similar manner, simple assessment of one or more dependent variables, e.g., self concept or revoked parole, is, of course, invalid without actual specification and control of independent variables. References to procedures as Positive Peer Culture, Behavior Modification, or psychoanalysis do little to guarantee consistency or comparability. The less systematized or structured a procedure the less one may predict results of its application.

Some specific recommendations can be made to improve the quality of reported research regarding PPC. More thorough behavioral descriptions, complete subject and leader data, and studies of longer duration would greatly improve the quality of information available. More thorough theoretical consideration should increase the predictive and construct validity of PPC procedures.

Most of the criticisms applicable to PPC research are not unique to that topic. Enthusiasm without substantive confirmation of effectiveness may reflect appreciable changes in attitude or behavior, but is insufficient proof of the value of any interventive method. PPC is a relatively new approach to the treatment of maladaptive adolescent behaviors. If it is to come of age as a distinctive procedure then

there must be some proof that PFC is sufficiently coherent and reliable.

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